

11197

## 11191 CERTIFICATE OF DEATH

Reg. Dist. No. 281

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Marys</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Marys</b>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <b>Dameron</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Dameron</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>				STREET ADDRESS (If rural give location) <b>Rural</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Alexander M. Barnes</b>				<b>4. DATE OF DEATH</b> <b>11 / 25 / 19 55</b>			
<b>5. SEX</b> <b>male</b>		<b>6. COLOR OR RACE</b> <b>colored</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>married</b>		<b>8. DATE OF BIRTH</b> <b>9/22/ 1888</b>	
<b>9. AGE last birthday</b> <b>67</b> yrs.		<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Inspector Insurance Co.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Insurance Co.</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>Maryland</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>Daniel O. Barnes</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Josephine O. Barnes</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>-----</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Blanch E. Barnes - Dameron, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>450.0 IMMEDIATE CAUSE (A)</b> <b>Congestive Heart Failure</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 years</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Arteriosclerosis</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 11-15, 1955, to 11-25, 1955, that I last saw the deceased alive on 11-15, 1955, and that death occurred at M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>[Signature]</i>				<b>ADDRESS (Street, city, town, state)</b> <b>M.D. 2nd Mills Rd</b>		<b>DATE SIGNED</b> <b>11-26-55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>11/29/55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>St. Peters Cemetery</b>		<b>LOCATION (City, town, or county)</b> <b>Ridge, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>11-29-55</b>		<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>[Signature]</i>		<b>ADDRESS</b> <b>Leonardtwn, Md.</b>	

INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE 18

11107

1. Name of deceased

John Doe

2. Sex

Male

3. Date of birth

Jan 1, 1900

4. Place of birth

London, England

5. Race

White

6. Occupation

Teacher

7. Cause of death

Heart disease

8. Date of death

Dec 1, 1955

BUREAU V. S.

DEC 2 1955

RECEIVED

11192 **CERTIFICATE OF DEATH**

11198

Reg. Dist. No. 287

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Marys</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Marys</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Leonardtwn</b>		LENGTH OF STAY (in this place) <b>1 wk.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Valley Lee</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>St. Marys Hospital</b>				STREET ADDRESS (If rural give location) <b>Rural</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Doctor William Briscoe</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>11 / 28 / 19 55</b>			
<b>5. SEX</b> <b>male</b>		<b>6. COLOR OR RACE</b> <b>colored</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>widowed</b>		<b>8. DATE OF BIRTH</b> <b>? - ? 1880</b>	
<b>9. AGE last birthday</b> <b>75</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>labor</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Benjamin Briscoe</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> -----		<b>17. INFORMANT &amp; ADDRESS</b> <b>Garfield Briscoe - Valley Lee, Md.</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>331X IMMEDIATE CAUSE (A)</b> <b>Cerebral hemorrhage</b>						<b>6 days</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Generalized arterio-sclerosis</b>						<b>10 years</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <b>0</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>2D. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <b>Nov 22 1955</b> to <b>Nov 28 1955</b> , that I last saw the deceased alive on <b>Nov 27, 1955</b> , and that death occurred at <b>4 A</b> M, from the causes and on the date stated above.							
<b>SIGNATURE</b> <i>[Signature]</i>				<b>ADDRESS</b> (Street, city, town, state) <i>[Address]</i>		<b>DATE SIGNED</b> <b>11/29/55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>11/30/55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>St. Marks Cemetery</b>		<b>LOCATION (City, town, or county)</b> <b>Valley Lee, Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>Nov 29/55</b>		<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>[Signature]</i>		<b>ADDRESS</b> <b>Leonardtwn, Md.</b>	

# CERTIFICATE OF DEATH

11198

Reg. Dist. No. 1

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Age (Years and Months)

4. Date of birth

5. Place of birth (Country, State, and County)

6. Date of death

7. Time of death

8. Cause of death (Immediate cause)

9. Duration of illness

10. Place of death

11. Name of physician (Print or write full name)

12. Signature of physician

13. Signature of registrar

14. Name of registrar (Print or write full name)

15. Signature of registrar

16. Signature of medical examiner

17. Name of medical examiner (Print or write full name)

18. Signature of medical examiner

19. Signature of coroner

20. Name of coroner (Print or write full name)

21. Signature of coroner

22. Signature of jury

23. Name of jury (Print or write full name)

24. Signature of jury

25. Signature of jury

26. Name of jury (Print or write full name)

27. Signature of jury

28. Signature of jury

29. Name of jury (Print or write full name)

30. Signature of jury

31. Signature of jury

32. Name of jury (Print or write full name)

33. Signature of jury

34. Signature of jury

35. Name of jury (Print or write full name)

36. Signature of jury

37. Signature of jury

38. Name of jury (Print or write full name)

39. Signature of jury

40. Signature of jury

41. Name of jury (Print or write full name)

42. Signature of jury

43. Signature of jury

44. Name of jury (Print or write full name)

45. Signature of jury

46. Signature of jury

47. Name of jury (Print or write full name)

48. Signature of jury

49. Signature of jury

50. Name of jury (Print or write full name)

51. Signature of jury

52. Signature of jury

53. Name of jury (Print or write full name)

54. Signature of jury

55. Signature of jury

56. Name of jury (Print or write full name)

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59. Name of jury (Print or write full name)

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61. Signature of jury

62. Name of jury (Print or write full name)

63. Signature of jury

64. Signature of jury

65. Name of jury (Print or write full name)

66. Signature of jury

67. Signature of jury

68. Name of jury (Print or write full name)

69. Signature of jury

70. Signature of jury

71. Name of jury (Print or write full name)

72. Signature of jury

73. Signature of jury

74. Name of jury (Print or write full name)

75. Signature of jury

76. Signature of jury

77. Name of jury (Print or write full name)

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80. Name of jury (Print or write full name)

81. Signature of jury

82. Signature of jury

83. Name of jury (Print or write full name)

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89. Name of jury (Print or write full name)

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92. Name of jury (Print or write full name)

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95. Name of jury (Print or write full name)

96. Signature of jury

97. Signature of jury

98. Name of jury (Print or write full name)

99. Signature of jury

100. Signature of jury

99. Name of jury (Print or write full name)

100. Signature of jury

101. Signature of jury

100. Name of jury (Print or write full name)

101. Signature of jury

102. Signature of jury

101. Name of jury (Print or write full name)

102. Signature of jury

103. Signature of jury

102. Name of jury (Print or write full name)

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104. Signature of jury

103. Name of jury (Print or write full name)

104. Signature of jury

105. Signature of jury

104. Name of jury (Print or write full name)

105. Signature of jury

106. Signature of jury

105. Name of jury (Print or write full name)

106. Signature of jury

107. Signature of jury

106. Name of jury (Print or write full name)

107. Signature of jury

108. Signature of jury

107. Name of jury (Print or write full name)

108. Signature of jury

109. Signature of jury

BUREAU V. 8

DEC 2 1955

RECEIVED

IMMEDIATE

11193 **CERTIFICATE OF DEATH**

11199

Reg. Dist. No. 281

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Mary's</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Mary's</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>X</b> TOWN <b>Hermanville</b>		LENGTH OF STAY (In this place) <b>Life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Hermanville</b>		<b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>				STREET ADDRESS (If rural give location) <b>1</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>John Harry Campbell</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Nov. 16, 1955</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>		<b>8. DATE OF BIRTH</b> <b>August 12, 1907</b>	
<b>9. AGE</b> last birthday <b>48</b> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Day Work</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Hazel Campbell</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Jannie R. Bryan</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <b>9</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Hazel Campbell Hermanville, Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
IMMEDIATE CAUSE (A) <b>Coronary occlusion</b>						<b>15 minutes</b>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <b>Enteritis</b>						<b>3 days</b>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <b>0</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <b>Aug 15, 1955</b> <b>to</b> <b>Nov 16 1955</b> , <b>that I last saw the deceased alive on</b> <b>Nov 15, 1955</b> , <b>and that death occurred at</b> <b>3:00A</b> <b>M</b> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>P. J. B...</b>				<b>ADDRESS</b> (Street, city, town, state) <b>Great Hill, Md.</b>		<b>DATE SIGNED</b> <b>11/17/55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>11/19/55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Our Lady's</b>		<b>LOCATION (City, town, or county)</b> <b>Medley Neck, Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>11/17/55</b>		<b>REGISTRAR'S SIGNATURE</b> <b>P. J. B...</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J. C. Mattingly</b>		<b>ADDRESS</b> <b>Lionardtown, Md.</b>	

INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled in by the funeral director, the third copy of this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



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BUREAU V. S.

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11200

11194

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St Mary's</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Mary's</b>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <b>X Leonardtown</b>		LENGTH OF STAY (in this place) <b>2 days</b>		CITY (If outside corporate limits, write RURAL end give nearest town) <b>Great Mills</b>		<b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>78 St Mary's Hospital</b>				STREET ADDRESS (If rural give location) <b>/</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <b>Infant</b>		(Middle) <b>Boy</b>		(Last) <b>Cecil</b>			
				<b>Nov. 4, 1955</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Single</b>		<b>8. DATE OF BIRTH</b> <b>Nov. 2, 1955</b>	
				<b>9. AGE last birthday</b> yrs. <b>2</b>		<b>IF UNDER 1 YEAR</b> Months <b>2</b> Days <b>2</b> Hours <b>1</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Norbert J. Cecil</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Madeline Gistlaine Messer</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Hospital Record</b>			
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>762.0 IMMEDIATE CAUSE (A)</b> <b>cerebral anoxia</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 day</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>massive infarction</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M.		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 11-2-55, 1955, to 11-4-55, 1955 that I last saw the deceased alive on 11-2-55, 1955, and that death occurred at 6:45 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>[Signature]</i>				<b>ADDRESS</b> (Street, city, town, state) <b>Great Mills, Md.</b>		<b>DATE SIGNED</b> <b>11-4-55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Nov. 4, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Holy Face</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Great Mills, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>[Signature]</i>		<b>ADDRESS</b> <b>Leonardtown, Md.</b>	
<b>DATE</b> <b>11-7-55</b>							

# CERTIFICATE OF DEATH

22

See last page

1. Name of deceased (Print or write)

St. Mary's Maryland

2. Date of death

Nov. 2, 1955

3. Place of death

St. Mary's Hospital

4. Sex

Female

5. Age

Single Nov. 2, 1955

6. Race

White

7. Usual residence

St. Mary's Hospital

8. Cause of death

9. Signature of physician

10. Signature of registrar

BUREAU A. 5

Nov. 8, 1955

Nov. 4, 1955

Nov. 4, 1955

SHORT MATCHES

1. Name of deceased (Print or write)  
2. Date of death  
3. Place of death  
4. Sex  
5. Age  
6. Race  
7. Usual residence  
8. Cause of death  
9. Signature of physician  
10. Signature of registrar



1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11201

Item 18 Film G189 11-29-55 am

11195

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Mary's</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Mary's</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Leonardtwn</b>		LENGTH OF STAY (in this place) <b>16 days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Rural Charlotte Hall</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>ST. MARY'S HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>1</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Caspay Dade</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Nov. 11, 1955</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Black</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>		<b>8. DATE OF BIRTH</b> <b>March 5, 1889</b>	
<b>9. AGE last birthday</b> <b>66</b> yrs.		<b>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Laborer</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Unknown</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b> <b>Y</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Joseph Dade Charlotte Hall, Md.</b>			
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>IMMEDIATE CAUSE (A)</b> <b>522X hypostatic pneumonia</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>ANTECEDENT CAUSE(S) (B)</b> <b>due to pulmonary tbc or</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)</b> <b>due to pulmonary metastasis</b>							
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Nov 11, 1955, to Nov 11, 1955, that I last saw the deceased alive on Nov 11, 1955, and that death occurred at A.M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>Leon Bente</b>				<b>DATE SIGNED</b> <b>11/14/55</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>11/15/55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Ebenezena</b>		<b>LOCATION (City, town, or county)</b> <b>Charlotte Hall, Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Paul C. House</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John C. Mattingly</b>		<b>ADDRESS</b> <b>Leonardtwn Md.</b>	

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

0-7-98

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6030

March 2, 1989

2218 refs.

1997

10006

BUREAU V. S.

1994

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11196  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11202  
Reg. Dist.

No. 281

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>St. Marys</b>		MARYLAND		STATE <b>New Jersey</b> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>TOWN R.F.D. Mechanicsville</b>		LENGTH OF STAY (in this place) <b>6 mo.</b>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Jersey City</b> <b>67X-3</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>428 New York Ave.</b>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)		(First) <b>Hattie</b>		(Middle) <b>Kuentzler</b>		(Last) <b>Dehrenbach</b>	
4. DATE OF DEATH		(Month) <b>11</b>		(Day) <b>24</b>		(Year) <b>1955</b>	
5. SEX: <b>female</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>widowed</b>	8. DATE OF BIRTH: <b>12/22/1874</b>	9. AGE last birthday: <b>80</b> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Domestic</b>		11. BIRTHPLACE (State or foreign country): <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Adolph Dehrenbach, Sr.</b>				14. MOTHER'S MAIDEN NAME: <b>Christina Kuntzler</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		(If Yes, give war or dates of service) <b>----</b>		16. SOCIAL SECURITY No.: <b>-----</b>		17. INFORMANT & ADDRESS: <b>R.F.D. 1 Lake Shore Pasadena, Md.</b>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							<b>1 day</b>
420.1 Immediate cause (a) <b>Coronary Occlusion</b>							
Antecedent cause(s) (b) <b>Arterio Sclerosis</b>							
Diseases or conditons, if any, giving rise to the above cause (c) <b>DUE TO</b>							
stating underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>none</b>							
19a. DATE OF OPERATION: <b>none</b>				19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <b>none</b>		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>none</b>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>none</b>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>[Signature]</b>				M. D. ASSISTANT MEDICAL EXAM. <b>[Signature]</b> <b>11/25/55</b>			
23. BURIAL, CREMATION, REMOVAL (Specify): <b>transportation</b>		DATE THEREOF <b>11/25/55</b>		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State) <b>Jersey City, New Jersey</b>	
DATE REC'D BY LOCAL REG. <b>11-29-55</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		24. FUNERAL DIRECTOR ADDRESS <b>P.B. Robinson- Leonardtown, Md.</b>			

Local

BUREAU V. S.

DEC 2 1955

RECEIVED

11197

## CERTIFICATE OF DEATH

Reg. Dist. No. 281

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Marys</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Marys</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>Beachville</b>		1 wk.		OR TOWN <b>Scotland</b>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				Rural			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>John Alexander Gatton</b>				<b>11 / 5 / 19 55</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
male	white	widowed	11 June 1879	76 yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
farming		Farm Tenant		Maryland		USA	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
George Gatton				Martha Cullison			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
no		-----		J. Earl Gatton - Dameron, Maryland.			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary sclerosis</u>				10 minutes			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)				5 years			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town)		(County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
		M.					
<b>22. I hereby certify that I attended the deceased from</b> <u>March</u> , 19 <u>53</u> , <b>to</b> <u>11-5</u> , 19 <u>55</u> , <b>that I last saw the deceased alive on</b> <u>11-4</u> , 19 <u>55</u> , <b>and that death occurred at</b> <u>9:15 P.M.</u> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>P. J. Beary M.D.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Great Mills, Md.</u>		<b>DATE SIGNED</b> <u>11-7-55</u>	
M.D.							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)	
Burial		11/8/55		St. Michaels Cemetery		Ridge, Maryland	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
DATE <u>11/7/55</u>		<u>P. J. Beary M.D. Local</u>		<u>P. B. Robinson</u>		<u>Leonardtown, Md.</u>	

INSTRUCTIONS

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M



# CERTIFICATE OF DEATH

Form No. 1001

1. Name of deceased

John Doe

John Doe

John Doe

John Doe

John Doe

2. Date of death

1912

1912

1912

1912

3. Place of death

Home

Home

Home

Home

4. Cause of death

Heart

Heart

Heart

Heart

5. Signature of physician

John Doe

John Doe

John Doe

John Doe

6. Signature of registrar

John Doe

John Doe

John Doe

John Doe

7. Signature of coroner

John Doe

John Doe

John Doe

John Doe

8. Signature of undertaker

John Doe

John Doe

John Doe

John Doe

9. Signature of witness

John Doe

John Doe

John Doe

John Doe

10. Signature of registrar

John Doe

John Doe

John Doe

John Doe

11. Signature of coroner

John Doe

John Doe

John Doe

John Doe

12. Signature of undertaker

John Doe

John Doe

John Doe

John Doe

13. Signature of witness

John Doe

John Doe

John Doe

John Doe

14. Signature of registrar

John Doe

John Doe

John Doe

John Doe

15. Signature of coroner

John Doe

John Doe

John Doe

John Doe

16. Signature of undertaker

John Doe

John Doe

John Doe

John Doe

17. Signature of witness

John Doe

John Doe

John Doe

John Doe

18. Signature of registrar

John Doe

John Doe

John Doe

John Doe

19. Signature of coroner

John Doe

John Doe

John Doe

John Doe

20. Signature of undertaker

John Doe

John Doe

John Doe

John Doe

21. Signature of witness

John Doe

John Doe

John Doe

John Doe

22. Signature of registrar

John Doe

John Doe

John Doe

John Doe

23. Signature of coroner

John Doe

John Doe

John Doe

John Doe

24. Signature of undertaker

John Doe

John Doe

John Doe

John Doe

25. Signature of witness

John Doe

John Doe

John Doe

John Doe

26. Signature of registrar

John Doe

John Doe

John Doe

John Doe

27. Signature of coroner

John Doe

John Doe

John Doe

John Doe

28. Signature of undertaker

John Doe

John Doe

John Doe

John Doe

BUREAU V. S.

RECEIVED

RECEIVED

RECEIVED

11198

11204  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 282

## 1. PLACE OF DEATH:

COUNTY **St. Mary's**

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWN **Bushwood**LENGTH OF STAY  
(in this place)  
**3 yrs.**HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **St. Mary's**CITY (If outside corporate limits write RURAL and give nearest town)  
OR  
TOWN **Bushwood**STREET ADDRESS  
(If rural, give location)3. NAME OF  
DECEASED:  
(Type or Print)

(First)

(Middle)

(Last)

**Walter****Benjamin****Goode**4. DATE  
OF  
DEATH

(Month) (Day) (Year)

**Nov. 25, 1955**

## 5. SEX:

**Male**6. COLOR OR  
RACE:**White**7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify):**Married Sept. 20, 1896**

## 8. DATE OF BIRTH:

9. AGE last birthday:

**59**

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,**Tide Water Fisherman**10b. KIND OF BUSINESS OR  
INDUSTRY:**Capt. Police Boat**11. BIRTHPLACE  
(State or foreign country):**Maryland**12. CITIZEN OF WHAT  
COUNTRY?**U.S.A.**

## 13. FATHER'S NAME:

**James Henry Goode**

## 14. MOTHER'S MAIDEN NAME:

**Unknown**15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)**3 No****None**

## 16. SOCIAL SECURITY No.:

**213-22-0243**

## 17. INFORMANT &amp; ADDRESS:

**Maude Vallandingham Bushwood, Md.**

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

**420.1**  
**Immediate cause**(a) **Coronary occlusion**  
DUE TO**Antecedent cause(s)**Diseases or conditions, if any,  
giving rise to the above cause  
stating underlying cause last(b) **Arterio-sclerosis**  
DUE TO  
(c)INTERVAL BETWEEN  
ONSET AND DEATH**medic****10 yr**II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.**rickets of liver**

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

**none**21a. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21b. PLACE (Home, farm, factory,  
OF street, office bldg., etc.,  
INJURY

## 21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY**none**21e. INJURY OCCURRED  
While at Not while  
work ☐ ☐ ☐

## 21f. HOW DID INJURY OCCUR?

**none**

## 20. AUTOPSY?

Yes ☐ No ☒22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and  
find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

**[Signature]**CHIEF MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒  
M. D. ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED

**11/25/55**23. BURIAL, CREMATION,  
REMOVAL (Specify):**Burial**

## DATE THEREOF

**11/28/55**

## NAME OF CEMETERY OR CREMATORY

**Sacred Heart**

## LOCATION (City, town, or county)

**Bushwood,****Maryland**DATE REC'D BY LOCAL  
REG.**11-28-55**

## REGISTRAR'S SIGNATURE

**[Signature]**

## 24. FUNERAL DIRECTOR

**Jos. C. Mattingley Leonardtown, Md.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 29 1955

RECEIVED

## 11199 CERTIFICATE OF DEATH

11205

Reg. Dist. No. 282

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate assembly should be detached for use as a burial transit permit in by the funeral director, the third copy of this

VS A15C 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Mary's</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Mary's</b>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
X TOWN <b>Rural Leonardtown</b>		<b>Life</b>		X TOWN <b>Rural Leonardtown</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)		(First) <b>Georgiana</b>		(Middle) <b>Guy</b>		(Last)	
4. DATE OF DEATH		(Month) <b>Nov.</b>		(Day) <b>5.</b>		(Year) <b>19 55</b>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Female</b>	<b>White</b>	<b>Widowed</b>	<b>October 9, 1865</b>	<b>90</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Housewife</b>		<b>Home</b>		<b>Maryland</b>		<b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>William Thomas Cullins</b>				<b>Jane Raley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<b>MR. THOMAS GUY Leonardtown, Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <b>Cerebral Thrombosis</b>						<b>12 hr</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Arteriosclerotic Cardiovascular disease</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)						<b>20 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan</b> , 19 <b>50</b> , to <b>Nov 5</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>Nov 4</b> , 19 <b>55</b> , and that death occurred at <b>8:30</b> M., from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>J. Roy Emyer</b>		<b>11/8/55</b>		<b>St. Aloysius</b>		<b>Leonardtown, Maryland</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<b>Burial</b>		<b>11-8-55</b>		<b>John B. Mattingly</b>		<b>Leonardtown, Md</b>	
DATE <b>11-8-55</b>		REGISTRAR'S SIGNATURE <b>Dean D. Hauser</b>		FUNERAL DIRECTOR'S SIGNATURE <b>John B. Mattingly</b>		ADDRESS <b>Leonardtown, Md</b>	

# CERTIFICATE OF DEATH

Reg. Dist. No.

DEPARTMENT OF HEALTH, BALTIMORE

DATE OF DEATH

County of Maryland

MARYLAND

St. Mary's

Burial Location

Burial Location

Nov.

Nov.

Georgetown

October 9, 1955

Widowed

Female White

Maryland

Home

Housewife

Jane Eley

William Thomas Online

St. Ignace

St. Ignace

*[Handwritten signature]*

*[Handwritten signature]*

DATE OF DEATH

BUREAU A. 8

DATE OF DEATH

1955

Georgetown, Maryland

St. Ignace

11/6/55

Female

ENCLOSURE

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11/10/00 BY 60322 UCBAW/STP



## 11200 CERTIFICATE OF DEATH

Reg. Dist. No. 282

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Mary's</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Mary's</b>	
CITY (If outside corporate limits, write RURAL or end give nearest town) <b>Compton</b>		LENGTH OF STAY (in this place) <b>Life</b>		CITY (If outside corporate limits, write RURAL end give nearest town) <b>Compton</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>50</b>				STREET ADDRESS (If rural give location) <b>1</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) (Middle) (Last) <b>Joseph Matthew Hazel</b>				<b>Nov. 5, 1955</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>May 25, 1883</b>	<b>9. AGE last birthday</b> <b>72</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>5</b> Days <b>11</b>	<b>IF UNDER 24 HRS.</b> Hours <b>11</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Storeowner</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Gen. Mdse.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>John J. Hazel</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Annie Lewis</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs Eva Alvey Leonardtown, Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>161X</b> IMMEDIATE CAUSE (A) <b>Carcinoma larynx</b>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST.							
(C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <b>0</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Feb 1952, to Nov 5, 1955, that I last saw the deceased alive on Nov 4, 1955, and that death occurred at 6:30 M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>J Roy Gopher</b> M.D.				<b>ADDRESS</b> (Street, city, town, state) <b>Mechanicsville</b>		<b>DATE SIGNED</b> <b>11/8/55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>11/9/55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>St. Francis Xavier</b>		<b>LOCATION (City, town, or county)</b> <b>Compton, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>11-8-55</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Paul D. Hauser</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>For C. Mattingly Leonardtown, Md.</b>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## CERTIFICATE OF DEATH

Reg. Dist. No.

2. Usual Residence (Household or Institution)

Place of Death

John A. Taylor

John A. Taylor

Compton

Compton

Maryland

Maryland

Joseph Nathan

Male White

Married May 22, 1883

32 11 3

U.S.A.

Maryland

Gen. 1883

Compton

John A. Taylor

John A. Taylor

Compton, Md.

John A. Taylor

None

John A. Taylor

Reg. Dist. No.

JOSEPH A. TAYLOR

11/10/22

Compton

Re. Francis Taylor

11/10/22

Compton

RECEIVED

MAY 10 1923

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11207

## 11201 CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>St. Mary's</u>	MARYLAND	STATE <u>Michigan</u>	COUNTY <u>Wayne</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Patuxent River, Md.</u>	LENGTH OF STAY (in this place) <u>46hrs. 25 Min.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park, Maryland</u>	TOWN <u>59X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Air Station Hosp. Patuxent River, Maryland</u>	STREET ADDRESS <u>34900 Glenwood Road</u> (If rural give location) <u>3</u>		
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Baby</u>	(Middle) <u>Boy</u>	(Last) <u>HOWELL</u>	(Month) <u>Nov</u> (Day) <u>9</u> (Year) <u>1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Specify): <u>single</u>	8. DATE OF BIRTH: <u>Nov 8 1955</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>2</u> yrs. <u>2</u> Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Franklin M. HOWELL</u>		14. MOTHER'S MAIDEN NAME: <u>Bernice Mary Summers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>9</u> (If Yes, give war or dates of service):		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT & ADDRESS: <u>Franklin M. HOWELL (father) 409 Yorktown Rd. Lexington Park, Maryland</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>776 X Prematurity, Neonatal Death (27 weeks gestation)</u>			<u>46 hours</u>
ANTECEDENT CAUSE (S):			<u>25 minutes</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
(B) <u>-----</u>			
(C) <u>-----</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION <u>-----</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	INJURY OCCUR? <u>-----</u>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>-----M.</u>	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>-----</u>	
22. I hereby certify that I attended the deceased from <u>8 Nov</u> , <u>1955</u> , to <u>9 Nov</u> , <u>1955</u> , that I last saw the deceased alive on <u>9 Nov</u> , <u>1955</u> , and that death occurred at <u>1150P M.</u> from the causes and on the date stated above.			
SIGNATURE <u>R. J. Irons</u>		DATE SIGNED <u>11-10-55</u>	
ADDRESS <u>Station Hospital, NAS Patuxent River, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Removal</u>	DATE THEREOF <u>11 Nov 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Face Cemetery</u>	LOCATION (City, town, or county) (State) <u>Great Mills, Maryland</u>
DATE REC'D BY LOCAL REGISTRAR <u>11-10-55</u>	REGISTRAR'S SIGNATURE <u>P. J. Bean, M.D.</u>	24. FUNERAL DIRECTOR <u>Franklin M. Howell, Lexington</u>	

RECEIVED

NOV 14 1955

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BUREAU V. M.

NOV 14 1955

RECEIVED

## 11202 CERTIFICATE OF DEATH

Reg. Dist. No. 282

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Mary's</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Mary's</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>Leonardtown</b>		<b>12 hrs.</b>		TOWN <b>Lexington Park</b>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>78 St. Mary's Hospital</b>				STREET ADDRESS (If rural give location) <b>327 Yorktown Road</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) (Middle) (Last) <b>Tell William Nicolet</b>				<b>Nov. 20, 19 55</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Male</b>	<b>White</b>	<b>Married</b>	<b>October 17, 1890</b>	<b>65</b> yrs.	Months <b>1</b>	Days <b>3</b>	Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Land Planner</b>				<b>Desota, Indiana</b>		<b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Luke A. Nicolet</b>				<b>Annie D. Casper</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>(Yes)</b>		<b>WW1</b>		<b>327 Yorktown Rd. Mildred Nicolet Lexington Park, Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>							INTERVAL BETWEEN ONSET AND DEATH
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
422.1 IMMEDIATE CAUSE (A) <b>Dissecting aneurysm - aorta</b>							<b>14 hrs</b>
ANTECEDENT CAUSE(S) DUE TO (B) <b>Arteriosclerotic CV disease</b>							<b>10 yrs</b>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M.		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Nov 19, 19 55</b> , to <b>Nov 20, 19 55</b> , that I last saw the deceased alive on <b>Nov 20, 19 55</b> , and that death occurred at <b>2:50</b> M. from the causes and on the date stated above.							
SIGNATURE <b>Roy Guyler</b>				ADDRESS (Street, city, town, state) <b>Mechanicsville, Md.</b>		DATE SIGNED <b>11/21/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>11/22/55</b>		<b>Poplar Hill</b>		<b>Valley Lee, Maryland</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <b>11-22-55</b>		<b>Glenn D. Houser</b>		<b>Joan Mattingly</b>		<b>Leonardtown, Md.</b>	

INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



# 11202 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

Name of Deceased Mary A. Nichols		Date of Death October 17, 1955	
Sex Female		Race White	
Date of Birth October 17, 1900		Place of Birth Decatur, Indiana	
Usual Residence 327 Yorktown Road Washington 25, D.C.		Present Residence 327 Yorktown Road Washington 25, D.C.	
Cause of Death 1. Myocardial Infarction 2. Hypertension		Manner of Death Natural	
Physician Dr. J. H. Nichols		Medical Examiner Dr. J. H. Nichols	
Signature of Physician J. H. Nichols		Signature of Medical Examiner J. H. Nichols	

RECEIVED  
 NOV 23 1955  
 BUREAU V. I.

MANUSCRIPT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. ....

<b>1. PLACE OF DEATH:</b> COUNTY <b>St Mary's</b> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Rural Bushwood</b> TOWN <b>Bushwood</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS _____ LENGTH OF STAY (in this place) <b>Life</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> STATE <b>Maryland</b> COUNTY <b>St. Mary's</b> CITY (If outside corporate limits write RURAL and give nearest town) <b>Rural Bushwood,</b> TOWN <b>Bushwood,</b> STREET ADDRESS (If rural, give location) _____	
<b>3. NAME OF DECEASED:</b> (Type or Print) <b>Johnson Bruce Quade</b> (First) (Middle) (Last)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Nov. 14, 1955</b>	
<b>5. SEX:</b> <b>Male</b>	<b>6. COLOR OR RACE:</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):</b> <b>Single</b>	<b>8. DATE OF BIRTH:</b> <b>1922 33</b> yrs.
<b>9. AGE last birthday:</b> <b>33</b> yrs.		<b>10. BIRTHPLACE (State or foreign country):</b> <b>Maryland</b>	
<b>11. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME:</b> <b>Bruce Johnson Quade</b>		<b>14. MOTHER'S MAIDEN NAME:</b> <b>Rose Milburn</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY No.:</b>	
<b>17. INFORMANT &amp; ADDRESS:</b> <b>Bruce Johnson, Hurry, Maryland</b>		<b>18. MEDICAL CERTIFICATION</b>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b> <b>322.2 Immediate cause</b> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>medial</b>	
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>none</b>		<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>19a. DATE OF OPERATION:</b> <b>none</b>		<b>19b. MAJOR FINDING OF OPERATION:</b> <b>none</b>	
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b>	<b>21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY</b> <b>none</b>	<b>21c. (City or town) (County) (State)</b> <b>none</b>	
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b> <b>none</b>	<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b> <b>none</b>	<b>21f. HOW DID INJURY OCCUR?</b> <b>none</b>	
<b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .</b> <b>SIGNATURE</b> _____ <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> _____ _____ <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/> <b>M. D. ASSISTANT MEDICAL EXAM.</b> <input type="checkbox"/>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>11/15/55</b>	
<b>NAME OF CEMETERY OR CREMATORY</b> <b>Sacred Heart</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Bushwood, Maryland</b>	
<b>DATE REC'D BY LOCAL REG.</b> <b>11/14/55</b>		<b>24. FUNERAL DIRECTOR ADDRESS</b> <b>Jos.C.Mattingley Leonardtown, Md.</b>	

BUREAU V. S.

NOV 18 1955

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## 11204 CERTIFICATE OF DEATH

Reg. Dist. No. 281

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Marys</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Marys</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>Piney Point Beach</b>				TOWN <b>Piney Point Beach</b>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
Pine Lodge							
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>Alfonso Rossi</b>				<b>Nov 3, 1955</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<b>male</b>	<b>white</b>	<b>married</b>	<b>7/12/1900</b>	<b>55</b> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>Retired violinist</b>		<b>Nat. Symphony</b>		<b>Italy</b>		<b>U.S.A.</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>Giovanni Rossi</b>				<b>Giovanna Rastelli</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>		<b>Wife</b>	
<b>no</b>		<b>579-16-9402</b>		<b>Ida Rossi</b>		<b>Piney Point Beach, Md.</b>	
<b>18. MEDICAL CERTIFICATION</b>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>150X IMMEDIATE CAUSE (A) Carcinoma of esophagus</b>							
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO</b>							
<b>STATING UNDERLYING CAUSE LAST. (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Corruptive heart failure</b>							
<b>INTERVAL BETWEEN ONSET AND DEATH</b>							
<b>4 months</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>			
<b>June 13, 1955</b>		<b>metastatic carcinoma of esophagus</b>		<b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>none</b>		<b>none</b>		<b>none</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>none</b>		<b>none</b>		<b>none</b>			
<b>22. I hereby certify that I attended the deceased from Sept. 6, 1955, to Nov. 3, 1955, that I last saw the deceased alive on Nov 2, 1955, and that death occurred at 2:20 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<b>Dr. R. J. Beatty</b>				<b>2901 14th St. NW</b>		<b>11/3/55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<b>burial</b>		<b>11/7/55</b>		<b>Rock Creek Cemetery</b>		<b>Washington, D.C.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>Nov 7, 1955</b>		<b>Dr. R. J. Beatty</b>		<b>The S. H. Wines Co.</b>		<b>2901 14th St. NW</b>	
<b>DATE</b>		<b>Nov 7, 1955</b>		<b>Nov 7, 1955</b>		<b>Washington, D.C.</b>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 153C 1-55 10M

1110

MAYLAND STATE DEPARTMENT OF HEALTH-84/THURSDAY 18

## 1204 CERTIFICATE OF DEATH

See Rev. No.

LOCAL REGISTRAR'S SIGNATURE

PLACE OF BIRTH

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## 11205 CERTIFICATE OF DEATH

Reg. Dist. No. 281

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Marys</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Marys</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>X</b> TOWN <b>St. Inigoes</b>		LENGTH OF STAY (in this place) <b>life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>St. Inigoes</b>		<b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00 Rural</b>				STREET ADDRESS (If rural give location) <b>Rural</b>		<b>1</b>	
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>Katherine</b>		(Middle) <b>Rosalice</b>		(Last) <b>Taylor</b>		(Month) <b>11 / 29 / 1955</b>	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>widowed</b>		8. DATE OF BIRTH <b>10 / 20 / 1875</b>	
9. AGE last birthday <b>80</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Dominic Raley</b>				14. MOTHER'S MAIDEN NAME <b>Alice Tarelton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT & ADDRESS <b>Mrs. Alice Knott - St. Inigoes, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
334X IMMEDIATE CAUSE (A) <b>Cerebral arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Generalized arteriosclerosis</b>				<b>10 years</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <b>Feb 18, 1955</b> , to <b>Nov 29, 1955</b> , that I last saw the deceased alive on <b>Nov 28, 1955</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.							
SIGNATURE <b>[Signature]</b>				ADDRESS (Street, city, town, state) <b>Great Mills Md</b>		DATE SIGNED <b>11/30/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>12/2/55</b>		NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b>		LOCATION (City, town, or county) <b>Ridge, Maryland.</b>	
24. REC'D BY REGISTRAR DATE <b>Nov 30/55</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>A. B. Robinson</b>		ADDRESS <b>Leonardtwn, Md.</b>	

INSTRUCTIONS

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Manner of Death		Signature of Physician	
Residence		Hospital		Signature of Registrar	
Date of Burial		Place of Burial		Signature of Minister	
Date of Inquest		Place of Inquest		Signature of Jury	
Date of Autopsy		Place of Autopsy		Signature of Pathologist	
Date of Exhumation		Place of Exhumation		Signature of Undertaker	
Date of Reinterment		Place of Reinterment		Signature of Cemetery	
Date of Cremation		Place of Cremation		Signature of Crematorium	
Date of Disposition		Place of Disposition		Signature of Disposer	

BUREAU V. S.

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REMARKS

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11206

## CERTIFICATE OF DEATH

Reg. Dist. No. 281

11212

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>St. Mary's</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>St. Mary's</b>
CITY (If outside corporate limits, write RURAL and give nearest town) <b>U.S. NAS</b>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park, Maryland</b>	
TOWN <b>Patuxent River, Md.</b>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>U.S. Naval Air Station Hosp. Patuxent River, Maryland</b>		STREET ADDRESS (If rural give location) <b>633 Chinlee Drive</b>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<b>Baby Boy WATSON</b>		OF DEATH: <b>Nov 29 1955</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>Caucasian</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>	8. DATE OF BIRTH: <b>Nov 27 1955</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <b>Maryland</b>
			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME: <b>Lloyd C. Watson</b>		14. MOTHER'S MAIDEN NAME: <b>Doris Anne Watts</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <b>Lloyd C. Watson 633 Chinlee Dr. Lexington Park, Md.</b>	
16. SOCIAL SECURITY NO.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <b>Prematurity, Neonatal Death</b>			<b>34 hours</b>
DUE TO (36 weeks gestation)			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
DUE TO (B)			
DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<b>2</b>			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>27 Nov., 1955</b> , to <b>29 Nov., 1955</b> that I last saw the deceased alive on <b>29 Nov., 1955</b> , and that death occurred at <b>6.08A</b> M, from the causes and on the date stated above.			
SIGNATURE <b>A. I. Feldman</b>		DATE SIGNED <b>29 Nov 1955</b>	
<b>A.I. FELDMAN LT MC USNR</b>		<b>Station Hospital NAS Patuxent River, Maryland</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		DATE THEREOF <b>29 Nov 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>St. Anthony's Medical Center Bethesda</b>		LOCATION (City, town, or county) (State) <b>Bethesda Md</b>	
DATE REC'D BY LOCAL REGISTRAR <b>Nov 29/55</b>		REGISTRAR'S SIGNATURE <b>A. S. Navy Patuxent River Md</b>	
24. FUNERAL DIRECTOR		ADDRESS	

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DEC 2 1955

BUREAU V. S.

11207 **CERTIFICATE OF DEATH**Reg. Dist. No. 282

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Marys</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Marys</b>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>Leonardtwn</b>		<b>4 wks.</b>		TOWN <b>Lexington Park</b>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)		/	
<b>78 St. Marys Hospital</b>				<b>31 Coral Place</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <b>Carl</b>		(Middle) <b>Edward</b>		(Last) <b>Wilkins</b>		<b>11 - 13 19 55</b>	
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<b>male</b>	<b>white</b>	<b>widowed</b>	<b>19 April 1906</b>	<b>49</b> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>Cab Driver</b>		<b>Taxi</b>		<b>West Virginia</b>		<b>USA</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>Unknown</b>				<b>Lottie Shippe</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<b>no</b>		<b>---</b>		<b>Eugene H. Wilkins- 31 Coral Place Lexington Park, Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>6 weeks.</b>	
<b>581.0 IMMEDIATE CAUSE (A) <u>Cirrhosis of Liver</u></b>							
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Acute Pancreitis</u></b>						<b>6 weeks.</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	
<b>none</b>		<b>none</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>none</b>		<b>none</b>		<b>none</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>none</b>		<b>none</b>		<b>none</b>			
<b>22. I hereby certify that I attended the deceased from <u>10/11</u>, 19<u>55</u>, to <u>11/13</u>, 19<u>55</u>, that I last saw the deceased alive on <u>11/12</u>, 19<u>55</u>, and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<b>11/13/55</b>				<b>Lexington Park, Md.</b>		<b>11/13/55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<b>Burial</b>		<b>11/16/55</b>		<b>St. Johns Cemetery</b>		<b>Ellicott City, Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>DATE 11/14/55</b>		<b>Clara A. House</b>		<b>BB Robinson</b>		<b>- Leonardtown, Md.</b>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed in by the funeral director, the third copy of this

death certificate assembly should be detached for use as a burial transit permit.

YS 115C 1-55 10M

1 The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed in by the funeral director, the third copy of this

death certificate assembly should be detached for use as a burial transit permit.



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Place of death		6. Cause of death	
7. Date of burial		8. Place of burial		9. Name of funeral home	
10. Name of physician		11. Name of coroner		12. Name of registrar	
13. Name of undertaker		14. Name of cemetery		15. Name of church	
16. Name of family		17. Name of friends		18. Name of neighbors	
19. Name of witnesses		20. Name of jury		21. Name of jury	
22. Name of jury		23. Name of jury		24. Name of jury	
25. Name of jury		26. Name of jury		27. Name of jury	
28. Name of jury		29. Name of jury		30. Name of jury	
31. Name of jury		32. Name of jury		33. Name of jury	
34. Name of jury		35. Name of jury		36. Name of jury	
37. Name of jury		38. Name of jury		39. Name of jury	
40. Name of jury		41. Name of jury		42. Name of jury	
43. Name of jury		44. Name of jury		45. Name of jury	
46. Name of jury		47. Name of jury		48. Name of jury	
49. Name of jury		50. Name of jury		51. Name of jury	
52. Name of jury		53. Name of jury		54. Name of jury	
55. Name of jury		56. Name of jury		57. Name of jury	
58. Name of jury		59. Name of jury		60. Name of jury	
61. Name of jury		62. Name of jury		63. Name of jury	
64. Name of jury		65. Name of jury		66. Name of jury	
67. Name of jury		68. Name of jury		69. Name of jury	
70. Name of jury		71. Name of jury		72. Name of jury	
73. Name of jury		74. Name of jury		75. Name of jury	
76. Name of jury		77. Name of jury		78. Name of jury	
79. Name of jury		80. Name of jury		81. Name of jury	
82. Name of jury		83. Name of jury		84. Name of jury	
85. Name of jury		86. Name of jury		87. Name of jury	
88. Name of jury		89. Name of jury		90. Name of jury	
91. Name of jury		92. Name of jury		93. Name of jury	
94. Name of jury		95. Name of jury		96. Name of jury	
97. Name of jury		98. Name of jury		99. Name of jury	
100. Name of jury		101. Name of jury		102. Name of jury	

BUREAU V. 2

RECEIVED

RECEIVED



**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11208 **CERTIFICATE OF DEATH**

11214

Reg. Dist. No. *282*

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Marys</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Marys</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X TOWN Laurel Grove</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Charlotte Hall,</b>		<b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>08 Rural</b>				STREET ADDRESS (If rural give location) <b>Rural</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Thomas Andrew Woodland</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>11/ 28 / 19 55</b>			
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>colored</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>married</b>	<b>8. DATE OF BIRTH</b> <b>10/6/1908</b>	<b>9. AGE last birthday</b> <b>47</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>tenant</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farm</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>William Woodland</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Bertha E. Dent</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>-----</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Bertha E. Woodland - Charlotte Hall, Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>191X IMMEDIATE CAUSE (A)</b> <i>Cachexia</i>							
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <i>Carcinoma toxic - origin unknown</i>						<i>1 yr</i>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b> <i>in perineal sweat gland</i>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <i>1 June 1955</i>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <i>metastasis from carcinoma</i>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <i>May</i> <b>19</b> <i>55</i> , <b>to</b> <i>Nov 28</i> <b>19</b> <i>55</i> , <b>that I last saw the deceased alive on</b> <i>Nov 28</i> <b>19</b> <i>55</i> , <b>and that death occurred at</b> <i>1:30</i> <b>P.M.</b> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>J. Roy Guyton</i> <b>M.D.</b>				<b>ADDRESS</b> (Street, city, town, state) <i>Mechanicville</i>		<b>DATE SIGNED</b> <i>11/28/55</i>	
<b>23. BURIAL, CREMATION REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>11/30/55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>St. Joseph Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Morganza, Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Alan D. Harvey</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>P.B. Robinson</i>		<b>ADDRESS</b> <i>Leonardtwn, Md.</i>	
<b>DATE</b> <i>12/1/55</i>							

11011

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

# 1908 CERTIFICATE OF DEATH

BUREAU V. S.

DEC 2, 1955

RECEIVED

DEC 2, 1955

DEC 2, 1955

RECEIVED